DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection 103 South Main Street, Ladd Hall Waterbury, VT 05671-2306 http://www.dail.vermont.gov Voice/TTY (802) 871-3317

To Report Adult Abuse: (800) 564-1612

Fax (802) 871-3318

September 25, 2012

Ms. Patricia Horn, Administrator Cedar Hill Health Care Center 49 Cedar Hill Drive Windsor, VT 05089

Provider #: 475046

Dear Ms. Horn:

Enclosed is a copy of your acceptable plans of correction for the re-certification survey conducted on **June 27, 2012.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN Licensing Chief

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PC:ne

Enclosure - This version replaces the former Accepted POC (survey dated 6/27/12) with cover letter dated August 1, 2012.



RECEIVED

Division of PRINTED: 09/04/2012 SEP 1 8 12 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES ensing an (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION Protection COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING B. WING 06/27/2012 475046 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 49 CEDAR HILL DRIVE **CEDAR HILL HEALTH CARE CENTER** WINDSOR, VT 05089 (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) **INITIAL COMMENTS** F 000 F 000 An unannounced on-site recertification survey was conducted by the Division of Licensing and Protection from 6/25/12 through 6/27/12. Based on the information gathered, the following regulatory violations were cited. 8/1/12 483.10(b)(11) NOTIFY OF CHANGES F 157 F 157 (INJURY/DECLINE/ROOM, ETC) All behaviors occurring more A facility must immediately inform the resident; than 2 days consecutively or consult with the resident's physician; and if occurring more than 3 times in a known, notify the resident's legal representative or an interested family member when there is an 7 day period will have MD accident involving the resident which results in notified via fax form. MD will injury and has the potential for requiring physician be responsible to respond to fax intervention; a significant change in the resident's with verification of his receiving physical, mental, or psychosocial status (i.e., a it and acknowledgment of deterioration in health, mental, or psychosocial status in either life threatening conditions or behaviors. MD may use this fax clinical complications); a need to alter treatment to initiate new orders or significantly (i.e., a need to discontinue an interventions. All initial faxes existing form of treatment due to adverse will be kept in the Fax log book consequences, or to commence a new form of treatment); or a decision to transfer or discharge until MD has returned signed the resident from the facility as specified in fax. The signed fax will be filed §483.12(a). in the back of the MD progress note section. If a new order is on The facility must also promptly notify the resident form, a copy will be placed in the

and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's

LABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE

Physician order section of chart

and taken off as a normal order.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 09/04/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
	475046				06/3	7/2012		
	PROVIDER OR SUPPLIER		B. WING 06/27/2012 STREET ADDRESS, CITY, STATE, ZIP CODE 49 CEDAR HILL DRIVE WINDSOR, VT 05089					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION JLL PREFIX (FACH CORRECTIVE ACTION SHOULD				
F 157	1 '	Continued From page 1 legal representative or interested family member.			,			
	by: Based on record refacility failed to notifincrease in combating 1 resident of 31 (Resample. The finding 1. Per review of the	e medical record, Resident		DNS/designee will monit Behavior sheets and PRN ensure that MD has been notified as outlined abov least 2 times a week. DNS/designee will audit fax book to ensure that N	N to e at the MD			
	diagnoses that inclu Per the psychologic the evaluation indicates history of dementia and evaluation indicates history of striking or nurse's notes, Resir an as needed (PRN behaviors and agita 5/25, 5/26, 5/27, 5/2 nurse's notes, the n #35 has sustained is combative behavior comprehensive care untoward effects of use" initiated on 12 that "if resident pres combative behavior Per review of th no documentation to of any increase in c 5/2/12 until 6/10/12	e plan titled "At risk for Haldol, Psychetropic drug /11/11, the care plan indicates		responded to faxes on a very basis. All nurses will be educate the new Behavior Fax for its process. F157 PC accepted 9 a 4 a 9 a 9 a 9 a 9 a 9 a 9 a 9 a 9 a	ed on			

Event ID: JDUP11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1` '	IULTIPLE CONSTRUCTION ILDING	(X3) DATE S COMPLE	URVEY ETED
	475046		B. WI	NG	06/2	7/2012
NAME OF PROVIDER OR SUPPLIER CEDAR HILL HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, Z 49 CEDAR HILL DRIVE WINDSOR, VT 05089		
(X4) ID PREFIX TAG			ID PREF TAG		CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 157	titled "Problematic policy indicates "th and inform the phy mental status, beh interview with the I he/she confirmed t informed from 5/2/increase in behavious that the resident should be the should	Behavior Management", the e staff will identify, document sician about an individual's avior, and cognition." Per DNS on 6/27/12 at 1:09 PM, that no physician had been 12 to 6/10/12 of Resident #35's lors, and the DNS confirmed nould have been re-assessed		157 280 Resident #15 Skin	Integrity risk	
	The resident has to incompetent or oth incapacitated under participate in plant changes in care at A comprehensive within 7 days after comprehensive as interdisciplinary temphysician, a register for the resident, and isciplines as determed and, to the extent the resident, the relegal representative.	er the laws of the State, to ning care and treatment or		care plan was imm updated to reflect reddened heels as a attempts by reside float/elevate heels a booties as preventi 1. The DNS did not that the red heels we getting better on R and that they remained they remained the sand in fact had res 3. The surveyor, the polygon of the surveyor, the polygon of the sand in fact had reserved.	history of well as failed nt refusal to and to use on. ot confirm were not esident #15 nined the same ed heels had ame since 4/20 olved.	
-	bv:	NT is not met as evidenced erview and record review the		RN responsible for to visually inspect the heels and noted that were healed and no pink.	the bilateral at the areas	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SU AND PLAN OF CORRECTION IDENTIFICATION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SI COMPLE	JRVEY TED
		475046	B. WING			06/27/201	
NAME OF PROVIDER OR SUPPLIER CEDAR HILL HEALTH CARE CENTER				49	EET ADDRESS, CITY, STATE, ZIP CODE 9 CEDAR HILL DRIVE /INDSOR, VT 05089		
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F 280	facility failed to reviplan for 1 resident (Resident #15) to remedical status with specific to meet the findings include: 1. Per review of the Resident #15 was red/18/12 with diagnosyncope. Per the rethe notes indicate to	se the comprehensive care of 31 in the Stage 2 sample effect the resident's current goals and interventions e resident's current needs. The emedical record on 6/27/12, re-admitted to the facility on oses that include dementia and ourses notes dated 4/20/12, that Resident #15 has	F	280	ADNS/designee will audit plans on a weekly basis to and audit for appropriate interventions that reflect current POC effective Jun 2012. Nurses will be educ proper procedure for upd care plans and will take p the over site and revision plans to ensure that any norder is followed up with	the ne 28, cated on lating art in of care ew	8/1/12
	for skin prep to hee nurses notes on 5/4 #15 has bilateral reprep was applied. If there was no evide interventions were bilateral reddened prevent reoccurren comprehensive cal titled "At risk for sk was no documenta and pink heels ider was no documenta interventions to hel reddened heels an Per interview with ton 6/27/12, he/she had been identified reddened heels. Til redness indicates preakdown and predoned the predo	da new order was obtained els three times a day. Per the 4, 5/11, 6/8 and 6/21, Resident dedened or pink heels and skin Per review of the nurses notes, nce that any other utilized to help resolve the heels and no interventions to ce. Per review of the e plan initiated on 4/30/12 in integrity impaired", there tion identifying the reddened ntified on 4/20/12, and there tion to indicate any specific p resolve the bilateral d prevent reoccurrence. The Director Of Nursing (DNS) confirmed that Resident #15 on 4/20/12 to have bilateral ne DNS indicated that the potential area for skin ressure sores to develop. The at the bilateral red heels were not that the area is remaining intified on 4/20/12. The DNS			- plan update. Interdiscipli team will review each care individually after each assessment to ensure that areas are covered. Nurses primary LNAs will be con before team meetings. Faso Pacacaptal flatlia	e plan all s and sulted	

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	475046			B. WING			7/2012
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F 280	three times a day. staff had attempted but he/she was nor that Resident #15 v	urses were utilizing skin prep The DNS indicated that the I to float the resident's heels accompliant. The DNS indicated wears shoes or slippers and at If to put him/her in a recliner to	F2	280			
	the DNS on 6/27/12 care plan dated 4/3 bilateral reddened h	omprehensive care plan with 2, he/she indicated that the 0/12 did not address the neels identified on 4/20/12,			·		
F 282	interventions to treat reoccurrence of the	RVICES BY QUALIFIED	F 2	282	All behaviors occurring mo		8/1/12
	must be provided b	led or arranged by the facility y qualified persons in ich resident's written plan of			occurring more than 3 time 7 day period will have MD notified via fax form. MD be responsible to respond t with verification of his received.	will to fax	
	by: Based on record refacility failed to prov 31 (Resident #35) if findings include:	NT is not met as evidenced eview and staff interview, the vide services for 1 resident of n the Stage 2 sample. The			it and acknowledgment of behaviors. MD may use th to initiate new orders or interventions. All initial fa will be kept in the Fax log until MD has returned sign	ixes book ied	
	#35 was admitted to diagnoses that inclu Per the psychologic the evaluation indic history of dementia	ne medical record, Resident to the facility on 12/4/11 with ude dementia with behaviors. cal evaluation dated 4/13/12, ates that Resident #35 has a and was seen for evaluation d behavior problems. The			fax. The signed fax will be in the back of the MD prog note section. If a new orde form, a copy will be placed Physician order section of and taken off as a normal of		

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		475046	B. WING			06/27/2012	
NAME OF PROVIDER OR SUPPLIER CEDAR HILL HEALTH CARE CENTER				49	EEET ADDRESS, CITY, STATE, ZIP CODE 9 CEDAR HILL DRIVE VINDSOR, VT 05089		
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F 282	evaluation indicates history of striking or nurse's notes, Resi an as needed (PRN behaviors and agita 5/23, 5/27, 5/28, 5/3 6/10/12. Per review notes indicate that I bruising as a result Per review of the co "At risk for untoward Psychotropic drug unistory of the great production of the company of the com	s that Resident #35 has a ut with care. Per review of the dent #35 was medicated with 1) dose of Ativan for combative ation on 5/2, 5/4, 5/10, 5/12, 81, 6/5, 6/7, 6/8, 6/9 and of the nurse's notes, the Resident #35 has sustained of his/her combative behavior.	F2		DNS/designee will monitor Behavior sheets and PRN to ensure that MD has been notified as outlined above a least 2 times a week. DNS/designee will audit th fax book to ensure that MI responded to faxes on a we basis. All nurses will be educated	e MD D has	
	Per review of the no documentation to of any increase in conference of titled "Problematic Expolicy indicates" the staff will idente physician about behavior, and cognibehavior monthly flowith the Director Of he/she indicated that the flow record were prior to the administrecord indicates and interventions (redirection to room, tilting changing resident's a back rub) were tricausing the nurses 5/25, 5/26, 5/27, 5/26	e behaviors then report to e physician notes, there was nat the physician was notified ombative behaviors until review of the facility's policy Behavior Management", the entify, document and inform an individual's mental status, tion." Per review of the ow record for May and June, Nursing (DNS) on 6/27/12, at the interventions listed on e tried and were unsuccessful tration of Ativan. The flow d the DNS confirmed that 11 ect, 1:1, ambulation, activities, g, giving food, giving fluid, position, encourage rest, and ed and were unsuccessful, on 5/11, 5/12, 5/23, 5/24, 8 and 5/31 to administer as gitation and combative			the new Behavior Fax form its process. Faba Pox accepted 9/24/12		

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F 282	behaviors. Per inter at 1:09 PM, he/she had been informed behaviors, and Res re-assessed for the 483.25(I) DRUG RE UNNECESSARY D Each resident's dru unnecessary drugs drug when used in	rview with the DNS on 6/27/12 confirmed that no physician of the increase in combative ident # 35 should have been increase in behaviors. EGIMEN IS FREE FROM RUGS g regimen must be free from An unnecessary drug is any excessive dose (including	F 2	•	immediately comp for Resident #25, s counseled, family a	Medication error report immediately completed for Resident #25, staff counseled, family and physician notified of medication error.	
	without adequate mindications for its us adverse consequent should be reduced a combinations of the Based on a compreseident, the facility who have not used given these drugs us therapy is necessar as diagnosed and drecord; and resident drugs receive gradubehavioral intervent contraindicated, in a drugs. This REQUIREMENT.	hensive assessment of a must ensure that residents antipsychotic drugs are not nless antipsychotic drug y to treat a specific condition ocumented in the clinical ts who use antipsychotic all dose reductions, and ions, unless clinically an effort to discontinue these			medication error. 2. Nurses will be edue on the procedure f Monthly MAR turby Omnicare on 7/DNS/designee to control of the ducation on montty MAR for those unsattend. 3. It is the expectation Cedar Hill that all will partake in the monthly MAR first reviews as the Firs Checks,	or nover 9/2012. omplete hly able to n of Nurses	8/1/12
		view and record review, the re that the medication			•		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
	475046				06/27/2012	
	PROVIDER OR SUPPLIER HILL HEALTH CARE	CENTER	s	TREET ADDRESS, CITY, STATE, ZIP COD 49 CEDAR HILL DRIVE WINDSOR, VT 05089	DE .	
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F 329	regimen of 1 resident sample (Resident unnecessary drugs dose of medication	age 7 ent of 4 reviewed in the stage 2 #25) remained free from s by administering a higher n than what was ordered by the asions during May 2012.	F 32	will be assigned and final checks MARS prior to to feach month. 5. It is the expectat	second on the start ion of	6/28/12
	Resident #25's me Physician's Order of dose of Ativan (an from 0.5 milligrams	w on 6/27/12 at 10:00 A.M. dical record contains a dated 4/20/12 decreasing the anti-anxiety psychotropic drug) s (mg) to 0.25 mg by mouth up		Cedar Hill that to Nurses who wor day of the month old MAR with numbers and compare both the second	k the first to take w MAR th MARS	
F 334	Notes for that day and that Resident approved the new Per record review, which includes a "r psychotropic drug anxiety". Approach "medications per o Notice on 4/30/12 I changes in medicat record review, Res Administration Record review, Res Administration Record documents a dose 5/4, 5/6, 5/10, 5/26 6/26/12 at 2:09 P.N. Nursing Services of Order decreasing F. Ativan on 4/20/12 v. MAR, and that Resords of Ativan large different occasions	Resident #25 has a Care Plan isk for untoward effects of use: Ativan used to treat es for the plan of care include rders". A Care Plan Action ists "Nursing: reviewed tion. Ativan decreased". Per ident #25's Medication ord (MAR) for May, 2012 of 0.5 mg of Ativan given on , & 5/29/12. Per interview on M., the facility's Director of onfirmed that the Physician's Resident #25's dosage of was not transcribed to the ident #25 was administered a er than the ordered dose on 5	F 33	during that pass third check to en MARS are accument to month. MAR process and icon problems will be revolved quarterly with Quality Assurance Committee. F329 POL accepted 9124	sure that rate from lentified riewed at the	

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F 334	The facility must de that ensure that (i) Before offering t each resident, or the representative receivements and potentimmunization; (ii) Each resident is immunization Octobro annually, unless the	he influenza immunization, ne resident's legal eives education regarding the tial side effects of the offered an influenza ber 1 through March 31 e immunization is medically the resident has already been	F3	334	Policy and Procedure for Influenza Immunizations revised to include the date the flu season as defined b Federal regulation (Octob through March 31), and to include that each resident, and/or resident representa will be given proper educa regarding influenza vaccin for that year as set forth b	s of y er 1 o ntive ntion	7/16/12
	(iii) The resident or representative has immunization; and (iv) The resident's documentation that following: (A) That the resid representative was the benefits and point immunization; and (B) That the resid influenza immunization on traindications of that ensure that (i) Before offering the immunization, each legal representative the benefits and point immunization; (ii) Each resident is immunization, unle	the resident's legal the opportunity to refuse medical record includes t indicates, at a minimum, the ent or resident's legal provided education regarding otential side effects of influenza ent either received the ation or did not receive the ation due to medical r refusal. evelop policies and procedures the pneumococcal r resident, or the resident's e receives education regarding otential side effects of the s offered a pneumococcal ess the immunization is dicated or the resident has			CDC. Annual consent for immunization will be obta Influenza Informed Conse forms will be revised to in section to document that education regarding the vaccination was given to the resident or representative time of requesting consent information will be kept in resident's record. The Infection Control Number designee will check to match at all consents are obtain before administration of value of the control of value of va	ined. ent clude a he at . This the rse or ke sure ned	7/16/12

AND PLAN OF CORRECTION			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
	475046		B. WING			06/27/2012			
		ROVIDER OR SUPPLIER	CENTER		49	EET ADDRESS, CITY, STATE, ZIP CODE 9 CEDAR HILL DRIVE /INDSOR, VT 05089			
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	F 334	Continued From page 9 (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding		F3		Quality Assurance Comm reviews flu vaccination po and procedures, and vaccinations pending and completed yearly during t season.	licy he flu		
		the benefits and po pneumococcal imm (B) That the reside pneumococcal imm	tential side effects of nunization; and ent either received the nunization or did not receive			F334 POC accepted 9/24/12 P	Medapa		
		contraindication or (v) As an alternative and practitioner rec pneumococcal imm years following the immunization, unless	e, based on an assessment commendation, a second nunization may be given after 5 first pneumococcal ss medically contraindicated or resident's legal representative						
		by: Based on record refacility failed to prove received for vaccine education provided risks of influenza in residents or their leapplicable stage 2 #13, #30), each tim Findings include:	NT is not met as evidenced eview and staff interviews, the vide documentation of consent e administration and/or regarding the benefits and munization, for 4 of 5 gal representatives in the sample (Residents #7, #11, ie the vaccine is offered.						
			.,						

Fax 8022412348

Jul 10 2012 02:28pm P014/014

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/10/2012 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 475046 06/27/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 49 CEDAR HILL DRIVE CEDAR HILL HEALTH CARE CENTER WINDSOR, VT 05089 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD RE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) Continued From page 10 F 334 1. Per record review, the facility failed to develop and implement a policy and procedure that assures that each resident or their legal representative has the opportunity to accept or refuse vaccination, and receives education regarding the benefits and side effects of the influenza vaccine each time it is offered. The facility's written procedure states that "Residents who received vaccine in previous years and who have signed or whose responsible party has signed will not have to renew permission". The written policy and procedure does not address education regarding benefits and side effects of the vaccine. The facility provided information which indicated that 8 residents received influenza vaccine during the 2011-12 influenza season. During record reviews, there was no evidence in the medical records of 4 of 5 residents in the stage 2 sample (Residents # 7, #11, #13, and #30) that they or their responsible party had either given consent for immunization or received education regarding the benefits and side effects prior to being administered the vaccine on 10/7/11. During an interview with the Assistant Director of Nursing (infection control nurse) on 6/27/12 at 10:45 AM, s/he confirmed that the facility could not provide evidence of consent by the residents or their responsible parties, or education provided

regarding benefits and side effects of the influenza vaccine prior to administration each

time the vaccine was offered.